

Request for Housing Accommodation due to Disability/Medical Needs

To be completed by student. (Please print clearly or type.)

Date: _____

Student Name: _____ Winthrop ID #: _____
(Last, First, MI)

Date of Birth: _____ Gender: _____

E-mail Address: _____ Phone Number: _____

Class: _____ Freshman/Sophomore (0-53 credit hours) _____ Junior/Senior (54+ credit hours)

Semester Requesting Accommodation: Fall Spring Summer Academic Year _____

Please describe the housing accommodation(s) you would like to request and explain why the accommodation(s) would be appropriate: _____

Documentation: (please check one)

_____ I have documentation on file in the Disability Services Office supporting my specific housing needs.

_____ I have not yet presented documentation to the Disability Services Office.

Authorization to Release Information

I acknowledge that an exchange of information may need to take place between the licensed clinician/medical professional noted in my documentation, Residence Life, Health & Counseling Services, including Services for Students with Disabilities, and/or other University staff. I give my permission for such communication when necessary.

Name of Licensed Professional: _____

Address: _____ Phone Number: _____

Student Signature: _____ Date: _____

*****ACCOMMODATION DEADLINE DATES*****

Requests for housing accommodations along with all required documentation must be received no later than **May 15th** for the Fall semester, and no later than **December 1st** for the Spring semester.

Office Use Only:

Date Received: _____ Date of Student Notification: _____

_____ Approved _____ Denied

Medical Information

To determine eligibility for housing accommodations Winthrop University requires current and comprehensive documentation of the student's disability or medical condition from a licensed clinician or medical professional. This individual must be involved in the direct treatment of the student and have a current and established relationship with that student.

Student Name: _____ Winthrop ID #: _____
(Last, First, MI)

To be completed by the clinician/medical professional. (Please print clearly or type.)

Specify current disability/ medical condition: _____

Level of Severity: ___Mild ___ Moderate ___ Severe

Duration: ___Temporary ___Permanent ___Chronic/Recurring

Date of diagnosis: _____

Date of initial contact with student: _____

Most recent contact with student: _____

If the accommodations are requested due to asthma or allergy related concerns please specify environmental triggers, frequency of attacks and diagnostic testing that has been completed to determine diagnosis and severity of condition.

Describe the *current impact* of the condition and the probable impact on the student's living situation.

Describe *treatments, medications, devices, or services currently prescribed* or used to minimize the impact of the condition.

Please identify the specific housing accommodations needed based on the functional limitation(s) caused by the student's disability/medical condition.

- | | |
|---|---|
| <input type="checkbox"/> Wheelchair accessible residence hall | <input type="checkbox"/> Modified equipment for deaf or hard of hearing persons |
| <input type="checkbox"/> Wheelchair accessible shower | <input type="checkbox"/> Year round air conditioning |
| <input type="checkbox"/> Limited stair climbing and/or must be on lower level | <input type="checkbox"/> Single room |
| <input type="checkbox"/> Must have wheelchair access to elevator | <input type="checkbox"/> Close to bathroom |
| <input type="checkbox"/> Wheelchair accessible furnishings | <input type="checkbox"/> In-room private bath |
| <input type="checkbox"/> Shower seat | |
| <input type="checkbox"/> Lowered closet rod | |

Other(s): _____

Explain how the requested accommodation(s) will be important to the student's treatment plan.

Describe *possible alternative* that could be considered if the preferred accommodation is not available.

Signature of Professional: _____ Date: _____

Name of Professional: _____ (*please print*)

License # _____ State: _____

Address: _____

Phone: _____ Fax: _____

Please submit documentation to:

Services for Students with Disabilities
Winthrop University
110A Crawford Building
Rock Hill, SC 29733
Phone: 803-323-3290
Fax: 803-323-4585